Health Check (Medicaid for Children)/ NC Health Choice

Order Form for 2013-14 Materials

(Orders mailed within 14 business days from receipt.)

ITEM (#)	QUANTITIES NEEDED	DATE NEEDED BY	MAILING ADDRESS (Delivery to street address--no PO Box) (print clearly)
#D3. HC/NCHC Envelope Stuffer (100/pack) **(Bilingual English/Spanish)**	[# packs]		CONTACT/NAME: MAILING ADDRESS: TELEPHONE #: Email: County: Agency (check one): _____ Local Health Department _____ Clinic/Hospital (Private) _____ Clinic/Hospital (Public) _____ School (LEA/Public) _____ School (Private) _____ OTHER (specify _____
#D4Br. HC/NCHC Fact Sheet ***(folded fact sheet; 100/pack)*** **(Bilingual English/Spanish)**	[# packs]		
#D5. HC/NCHC Poster **(order # needed)** **(Bilingual English/Spanish)**	[#]		
#D6E. HC/NCHC Applications—English **(100/pack)**	[# packs]		
#D6S. HC/NCHC Solicitud--Español **(100/pack)**	[# packs]		

PLEASE PRINT FORM

&

FAX THIS COMPLETED FORM TO:

DPH—Children & Youth Branch

ATTN: HC/NCHC OUTREACH MATERIALS

FAX: 919-870-4880

FOR OFFICE USE	Date Rec'd DPH:	Staff initials:
	Date Sent to WRHS:	Staff initials